STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/04/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LEGACY LIVING AND REHABILITATION CENTER	**1000 S DOUGLAS HWY** **GILLETTE, WY 82716**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on December 4, 2019. Requirements for Long Term Nursing Homes Section 42 CFR 483.70 (a) except as otherwise provided in the section, the facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code, Existing Health Care of the National Fire Protection Association. The facility was a fully sprinklered, two story building with a basement of Type II (111) built in 2016. The building was equipped with a supervised automatic wet and dry sprinkler system with an addressable fire alarm system. The facility had a capacity of 160 certified Medicare and Medicaid beds with a census of 145 residents. .	K 000		
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain means of egress in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain means of egress as	K 211	Correction for cited residents/environment: Spruce Activity Exterior Door 1. Snow blocking door egress at Pine	1/19/20

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 211	Continued From page 1 required could delay egress resulting in injury or death during an emergency. The deficiencies affected two (2) of numerous exits. The findings were: 1. Observation on 12/04/2019 at 10:50 AM at the Pine Place activity room exit revealed the sidewalk partially covered with snow which prevented the door from opening fully. Interview with the facility maintenance staff at the time of observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.7.3.1; 7.1.10.1 2. Observation on 12/04/2019 at 12:04 PM at the Spruce Street activity room revealed an exterior door that when tested required more than 30 pounds of force to set the door in motion. Interview with the facility maintenance staff at the time of observation acknowledged the door exceeded 30 pounds of force to open, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.2.2.2.1; 7.2.1.4.5 .	K 211	Place activity room removed 12/04/19 2. Door at Spruce Activity Exterior Door repaired that when tested did not require more than 30 pounds of pressure to set the door in motion. 12/20/19 Identification of other residents: All residents/staff have the potential to be affected by failure to maintain egress as required. Systematic changes and Monitoring: Monthly audit of egress doors to be completed maintenance via electronic PM system Education to staff 01/19/20 regarding egress doors function and obstruction Education to snow removal vendor 12/04/19 related to snow obstruction removal Outcome: 100% of egress doors will require less than 30 pounds of pressure to open. Data will be collected by plant operations/designee and will be aggregated and reported quar5terly at long term care quality meetings and discrepancies investigated and reported.	
K 222 SS=D	Egress Doors CFR(s): NFPA 101	K 222		1/19/20

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K 222	Continued From page 2 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and	K 222		

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K 222	Continued From page 3 ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain egress doors in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain egress doors as required could result in injury or death during an emergency. The deficiency affected one (1) of numerous exits. The findings were: Observation on 12/04/2019 at 10:24 AM at the first floor stairwell 3 door revealed the delayed egress locking system failed to operate as designed. When tested the release process failed to activate an audible signal in the vicinity of the door as required, and failed to release the door after 15 seconds. The door could only be released by punching in a code.	K 222	Correction for cited residents/environment: 1. First floor stairwell 3 door delayed egress locking system repaired and activated an audible signal in the vicinity of the door. Door also unlocked with 15 second delay 12/05/19 Identification of other residents: All residents/staff have the potential to be affected by failure to maintain egress as required. Systematic changes and monitoring: Monthly audit of egress doors to be completed by plant ops via preventive maintenance electronic system	

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K 222	Continued From page 4 Interview with the facility maintenance staff at the time of observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.2.2.2.4; 7.2.1.6.1.1 (3) .	K 222	Education to staff 01/19/20 regarding egress doors function. Outcome: 100% of egress doors will activate an audible signal in the vicinity of the door and release the door after 15 seconds Data will be collected by plant operations/designee and will be aggregated and reported quarterly at long term quality meetings and discrepancies investigated and reported.	
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons)	K 321		1/19/20

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K 321	Continued From page 5 e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous area enclosures in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain hazardous area enclosures as required could result in injury or death during an emergency. The deficiency affected one (1) of numerous rooms in the facility. The findings were: Observation on 12/04/2019 at 10:16 AM in the EVS storage room revealed the self closing door failed to close when tested. Further observation of the EVS storage room corridor door revealed that the door coordinator failed resulting in the self closing door failing to close. Interview with the facility maintenance staff at the time of observation acknowledged the doors failure to close, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Section: 19.3.2 .	K 321	Correction for cited residents/environment: 1. EVS storage room self-closing door repaired 12/05/19 2. EVS door coordinator repaired function appropriately 12/05/19 Identification of other residents: All residents/staff have the potential to be affected by failure to maintain hazardous area enclosures and auto closures as required. Systematic changes and monitoring: Monthly audit of self closing doors and door coordinators to be completed by plant ops via preventive maintenance electronic system Education to staff 01/19/20 regarding automatic closure doors and function. Outcome: 100% of self closing doors and door coordinators to hazardous areas will function appropriately and positively latch. Data will be collected by plant operations/designee and will be aggregated and reported quarterly at long term quality meetings and discrepancies investigated and reported.	
K 372	Subdivision of Building Spaces - Smoke Barrie	K 372		1/19/20

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K 372 SS=D	Continued From page 6 CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain fire barriers in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain fire barriers as required could result in fire spread resulting in injury or death. The deficiency affected one (1) of approximately six (6) smoke/fire barriers. The findings were: Observation on 12/04/2019 at 1:30 PM at the fire barrier on the west side of the atrium revealed several penetrations in the fire barrier which were not protected by a firestop system or device. Interview with the facility maintenance staff at the time of observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency.	K 372	Correction for cited residents/environment: 1. Fire wall penetration repaired on the west side of the atrium 12/16/19. Identification of other residents: All residents/staff have the potential to be affected by failure to maintain fire barriers in accordance with the 2012 NFPA 101 Life Safety Code. Systematic changes and monitoring: 1.Education to staff 12/12/19 and 01/19/19 related to fire wall penetrations and smoke compartments. 2.Inspection of all fire walls in the facility for penetrations as a baseline and annually thereafter 3. Visual inspection consistent with above ceiling permit for contractors to ensure penetrations are sealed appropriately.	

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K 372	Continued From page 7 REF: 2012 NFPA 101, Sections: 19.3.6; 8.3.1; 8.3.5 .	K 372	Outcome: 100% of fire walls will have penetrations sealed with appropriate fire stop system or device. Data will be collected by plant operations/designee and will be aggregated and reported quarterly at long term quality meetings and discrepancies investigated and reported.	
K 711 SS=D	Evacuation and Relocation Plan CFR(s): NFPA 101 Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to provide a fire safety plan in accordance with the 2012 NFPA 101, Life Safety Code. Failure to provide a fire plan as required could result in injury or death during an emergency. The deficiency affected 1 of 9 provisions of the fire safety plan. The findings were:	K 711	Correction for cited residents/environment: 1. Fire safety plan revised to include emergency phone call to the fire department as required. Identification of other residents: 1. All residents/staff have the potential to	1/19/20

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K 711	Continued From page 8 Document review on 12/04/2019 at 4:00 PM revealed that the fire safety plan did not provide for the emergency phone call to the fire department as required. Interview with the facility maintenance staff at the time of observation acknowledged the deficiency, and indicated they were unaware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.7.1.1; 19.7.2.2(3) .	K 711	be affected by failure to provide a fire safety plan in accordance with the 2012 NFPA 101 Life Safety Code Systematic changes and monitoring: 1.Education to all staff 01/19/20 2.Revision of fire plan to include emergency call to the fire department. Outcome: 1. Annual review of fire plan will demonstrate compliance with Life safety code regulations. 2. Data will be collected by Administrator or designee and will be aggregated and reported at organization EOC meeting and discrepancies investigated and reported.	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a	K 920		1/19/20

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K 920	Continued From page 9 substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain electrical systems in accordance with the 2012 NFPA 101, Life Safety Code and the 2011 NFPA 70, National Electrical Code. Failure to maintain electrical systems as required could cause a fire resulting in injury or death. The deficiency affected one (1) of numerous rooms in the facility. The findings were: Observation on 12/04/2019 at 11:05 AM in room 1313 revealed an extension cord. Further observation revealed a lamp plugged into the extension cord. Interview with the facility maintenance staff at the time of observation acknowledged the extension cord, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.5.1.1; 9.1.2 2011 NFPA 70, Section: 400-8	K 920	Correction for cited residents/environment: 1. Extension cord removed from resident room 1313 12/04/19 Identification of other residents: 1. All residents/staff have the potential to be affected by failure to maintain electrical systems in accordance with the 2012 NFPA 101 Life Safety code and the 2011 NFPA 70 National Electrical code. Systematic changes and monitoring: 1.Education to all staff 01/19/20 related to electrical safety (extension cords and power strips) 2.Policy review and revision Resident/environmental and equipment safety 01/19/20 3. Audit of rooms daily by EVS staff for extension cords and surge protectors. Outcome: 1. 100% of patient rooms will be free of electrical extension cords and power surge protectors 2. Data will be collected by Administrator or designee and will be aggregated and reported quarterly at organization EOC	

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K 920	Continued From page 10	K 920	meeting and LTC quality committee and discrepancies investigated and reported.	

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E 000	Initial Comments An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on December 4, 2019.	E 000		
E 006 SS=F	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. *[For LTC facilities at §483.73(a)(1):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a)(1):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented,	E 006		1/19/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/23/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING _____ B. WING _____	12/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LEGACY LIVING AND REHABILITATION CENTER	1000 S DOUGLAS HWY GILLETTE, WY 82716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 006	Continued From page 1 facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This REQUIREMENT is not met as evidenced by: Document review and staff interview revealed the facility failed to maintain and develop a facility and community based risk assessment in accordance with 42 CFR 483.73. Failure to provide a risk assessment could result in injury or death during an emergency. The deficiency affected one (1) of four (4) core elements of the Emergency Preparedness Program. The findings were: Document review of the Emergency Preparedness Plan on 12/04/2019 at 4:30 PM revealed that the facility did not include missing persons as part of their all hazard risk assessment. Missing persons must be included as part of the risk assessment. Interview with the facility administrator revealed that the facility had	E 006	Correction for cited residents/environments: Missing residents included in the HVA all risks assessment 01/19/20 Identification of other residents: All residents/staff have the potential to be affected by not having missing residents as part of all hazard risk assessment. Systematic changes and monitoring: Education on HVA to all staff 01/19/20 HVA regulations review annually prior to HVA completion annually for any updates Outcomes: 100% of HVA will contain 4 core elements.	

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E 006	Continued From page 2 a policy and procedure for missing persons, but did not include it as part of the risk assessment. Interview with the facility administrator at the time of observation and exit acknowledged the deficiency, and indicated she was unaware of the missing persons requirement. REF: 42 CFR 483.73(a)(1)	E 006	Data will be collected Administrator/designee and will be aggregated and reported annually at Emergency preparedness meetings and discrepancies investigated and reported.	